Child's Name: _____Date of Birth: _____

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes.

Check all that apply….

Plan was created by:

____ Parent
____ Doctor or Licensed Practitioner
____ Program's Health Care Consultant
____ Older school age child (9+ years of age)
____ Other: _____

Plan is maintained by:

_____ Director
_____ Assistant Director
_____ Child's Educator
_____ Other: _____

Name of Child: Date:
Any change to the child's Health Care Plan? **YES** (indicate changes below) **NO** (updated physician/parental signature required)
Name of chronic health care condition:
Description of chronic health care condition
Symptoms:
Medical Treatment necessary while at the program:
Potential side effects of treatment:
Potential consequences if treatment is not administered:
Name of educators that received training addressing the medical condition:
Person who trained the educator (child's Health Care Practitioner, child's parent, program's Health Care Consultant):

Name of Licensed Health Care Practitioner (Please Print): _____

Licensed Health Care Practitioner authorization: _____ Date: _____

Parent/Guardian Consent: _____ Date: _____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medication for use as needed.

Age of child _____ Date of birth _____ Back-up medication received? YES NO

Parent's Signature: _____ Date: _____

Administrator's Signature: _____ Date: _____

Commonwealth of Massachusetts
Department of Early Education and Care
Medication Consent Form 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please √ one of the following: Prescription _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms _____

Tropical Non-Prescription (applied to open wound/broken skin) _____

My child has previously taken this medication _____

My child has not previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan _____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:
_____
Child's Health Care Practitioner _____ Date: _____

I, _____, (parent or guardian) gives
Print name
permission to authorize educator(s) to administer medication to my children as indicated above.

Parent/Guardian Signature: _____ Date: _____

For topical, non-prescription NOT applied to open wound/broken skin (Parent signature only)